**August 1999**


# Provider Handbook

- Provider Eligibility
- Covered Services
- Billing Instructions

**Wisconsin Health Insurance Risk Sharing Plan (HIRSP)**
**Division of Health Care Financing**
**Department of Health and Family Services**
6406 Bridge Road, Suite 18 • Madison, WI 53784-0018
Phone (608) 221-4551 or (800) 828-4777

Date: July 26, 1999

To: HIRSP Providers

From: HIRSP Customer Service

Re: New provider handbook

Thank you for your interest in the Wisconsin Health Insurance Risk Sharing Plan (HIRSP). This is your copy of the HIRSP Provider Handbook.

The handbook contains important information about billing instructions and covered services. The service provider and the billing staff must review the material thoroughly to assure compliance with HIRSP requirements.

Providers will be notified of changes to the HIRSP Provider Handbook. Other information about HIRSP is available under Chapter 149, Wis. Stats., and HFS 119, Wis. Admin. Code.

Providers of medical services are required to be Wisconsin Medicaid certified to provide services to HIRSP policyholders. However, providers are not required to accept Medicaid patients.

If you have questions about HIRSP, please write or call the numbers listed above.

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## A. Effective Date of New Billing Requirements

Effective September 1, 1999, the billing requirements for the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) change to those described in this handbook. HIRSP uses many of Wisconsin Medicaid's billing requirements and policies. This handbook describes the HIRSP billing requirements and policies that are different from those used by Wisconsin Medicaid. Section 6: Billing Requirements & Covered Services highlights where HIRSP policy differs from Wisconsin Medicaid policy as written in provider handbooks and Updates.

HIRSP providers billing claims on and after September 1, 1999, are required to use these new procedures for all claims. The new procedures apply for dates of service prior to September 1, 1999, if providers are submitting claims after September 1, 1999.

To receive reimbursement for services, all providers treating HIRSP policyholders on and after August 1, 1998, are required to be Wisconsin Medicaid certified.

Failure to adhere to the requirements stated in this handbook will result in claim denial.

## B. Type of Insurance

HIRSP was created in 1979 for Wisconsin residents. This plan makes health insurance available to people who are unable to find adequate health insurance coverage in the private market due to their mental and/or physical condition. Two plans are available to eligible persons under the HIRSP major medical policy. Plan 1 is for persons who are not eligible for Medicare. Plan 2 is for persons who are under 65 years of age on the date of application to HIRSP and eligible for Medicare.

HIRSP requires providers to be Wisconsin Medicaid certified, but HIRSP is not connected with Medicaid. HIRSP is not an entitlement program. HIRSP is a separate program with its own reimbursement methodology, covered services, benefit limitations, and other procedures.

## C. Organizational Structure

The Wisconsin Department of Health and Family Services (DHFS) is the state agency designated to administer HIRSP. The DHFS contracts with a fiscal agent to maintain HIRSP's provider certification files, to process HIRSP claims, and to answer policy/billing questions about HIRSP. The Wisconsin Medicaid fiscal agent also serves as HIRSP's plan administrator.

## D. HIRSP and Wisconsin Medicaid

This handbook identifies the general categories of HIRSP-covered services and instructs providers how to bill for those services. Many HIRSP policies are comparable to those applied to Wisconsin Medicaid claims, and this handbook instructs providers when to use Wisconsin Medicaid billing materials. HIRSP will issue updates to the HIRSP handbook should any policies change. Wisconsin Medicaid also issues handbook replacement pages and Updates announcing changes in Wisconsin Medicaid policies.

HIRSP may instruct providers to use Wisconsin Medicaid billing materials. In these instances, HIRSP will refer providers to Wisconsin Medicaid policy. When Wisconsin Medicaid changes such shared billing requirements or policies, HIRSP's billing requirements or policies will also change, unless HIRSP indicates otherwise.

HIRSP and Wisconsin Medicaid have different covered services and benefit limitations. Do not rely on Wisconsin Medicaid materials to determine if HIRSP covers a service. Providers should contact HIRSP Customer Service (see next page) to verify that HIRSP covers a service if a service is not indicated in Section 5: Noncovered Services or Section 6: Billing Requirements & Covered Services.

## E. Provider Inquiries

Provider inquiries regarding benefits may be directed to HIRSP Customer Service at the following address and telephone numbers:

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018
(800) 828-4777 or (608) 221-4551

When providers contact HIRSP Customer Service for assistance, it is necessary that inquiries, both telephone and written, include the following information when applicable:

1. Provider name and eight-digit Wisconsin Medicaid provider number.
2. Policyholder name and 10-digit HIRSP identification number.
3. Claim number.
4. Date of service.
5. Amount billed.
6. Remittance and Status (R/S) Report date.
7. Procedure code of service in question.
8. Reference to all HIRSP procedures that address the situation.

Please do not contact Wisconsin Medicaid correspondents or field representatives with HIRSP inquiries. For further information about contacting HIRSP, please refer to the addresses and telephone numbers listed in Appendix 1.

For written inquiries, providers should use the HIRSP provider inquiry form shown in Appendix 2. Providers may photocopy Appendix 2 as needed for written inquiries.

## F. Customer Service Unit

The HIRSP Customer Service telephone lines are staffed from 8:30 a.m. to 4:30 p.m., Monday through Friday, except on Tuesday mornings when the telephone lines are not staffed until 9:30 a.m. The Customer Service telephone lines are not staffed on weekends and holidays.

Information available from Customer Service by telephone or in writing includes:

- Policy information concerning covered services and limitations.
- Assistance with completing claim forms.
- Claim status checks. Please limit the number of inquiries and wait at least 20 days after claim submission. Providers whose claim does not appear on an R/S Report within 30 days should call Customer Service as a follow-up procedure to claim submission.
- Policyholder eligibility status.

## A. Certification Requirement

Providers are required to be Wisconsin Medicaid certified to receive payment from the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) for claims with service dates on and after August 1, 1998.

All providers located in Wisconsin and outside of Wisconsin are required to obtain this certification before providing services to HIRSP policyholders, except for urgent or emergent services. Emergent is defined as any condition in which a delay in treatment may result in permanent impairment of the policyholder's health. Urgent is defined as an acute condition, less serious than an emergency, yet necessitating prompt health care services.

Medicaid certification does not require providers to accept Wisconsin Medicaid recipients.

## B. Eligibility

All Wisconsin and out-of-state providers of HIRSP services are eligible for certification if they:

- Are licensed/certified providers in their state of practice.
- Have not been denied Medicare or Medicaid participation in their state of practice, unless the denial was only because the services are not a covered Medicare or Medicaid benefit in their state of practice.

## C. Fiscal Agent

The Wisconsin Medicaid fiscal agent processes Medicaid provider certification requests, changes of provider status, and termination requests. Providers are required to deal directly with the fiscal agent for all certification-related business. Providers are responsible for informing the fiscal agent of changes in status (e.g., change of address).

## D. Certification Procedure

Providers may request an application for Wisconsin Medicaid certification either by telephone or a written request to the fiscal agent. HIRSP encourages providers to contact the fiscal agent for certification materials at the time the materials will be submitted because Wisconsin Medicaid periodically revises application materials, including provider agreements. Submission of outdated materials may result in delayed certification.

Telephone requests to obtain certification materials may be made by contacting Provider Services at (800) 947-9627 or (608) 221-9883. Written requests should be sent to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Include the following information for each applicant's certification request:

- Name.
- Address.
- Telephone number.
- Type of provider (e.g., physician, physician clinic or group, speech pathologist, hospital).

## D. Certification Procedure (continued)

- Number of applications requested.
- Indication of previous certification in Wisconsin Medicaid, when applicable.

If Wisconsin Medicaid requires HIRSP providers to be Medicare certified, providers are required to submit the appropriate Medicare certification materials with the Wisconsin Medicaid application. Wisconsin Medicaid certification materials tell providers whether they need Medicare certification. HIRSP encourages providers to apply for certification to Wisconsin Medicaid at the same time they apply to the Medicare program. Delays in applying to Wisconsin Medicaid may result in assignment of an effective date that is different than the certification effective date for Medicare.

## E. Provider Numbers

All providers, whether individuals, agencies, or institutions, are assigned and required to use their eight-digit Wisconsin Medicaid provider number to bill HIRSP for services rendered to a HIRSP policyholder. A provider number belongs solely to the person, agency, or institution to which it is issued.

Three types of provider numbers are issued, each of which has designated uses and restrictions.

### Billing Performing Provider Number

Wisconsin Medicaid issues a billing performing provider number to those providers who may independently bill HIRSP. Providers who may receive a billing performing provider number include both individuals, such as physicians, and institutions, such as hospitals and nursing homes. These providers may bill and receive reimbursement using only their assigned single billing performing provider number.

### Nonbilling Performing Provider Number

Wisconsin Medicaid assigns nonbilling performing provider numbers to individuals who are required to be under professional supervision to be eligible providers. Such a number may not be used to independently bill HIRSP. These providers include individuals such as physical therapy assistants, occupational therapy assistants, and physician assistants.

Providers assigned a nonbilling provider number are required to submit claims to HIRSP using one of the following two methods:

- Use the nonbilling provider number (e.g., physical therapy assistant) as the performing provider and the billing provider number (e.g., a licensed physical therapist) of the individual supervising the service. The supervisor receives all reimbursement when the provider is the payee on the claim.

- If employed by a Wisconsin Medicaid-certified facility, submit claims using the non-billing provider number (e.g., physician assistant) as the performing provider and the group billing number assigned to the facility (e.g., physician clinic). The facility receives all reimbursement when the provider is the payee on the claim.

### Group Billing Number

A group billing number is primarily an accounting convenience. It is issued to clinics, usually physician or chiropractic clinics. When a clinic has a group billing number, all payments for claims on which that number is used will be made directly to the clinic for covered services performed by clinic staff. It also enables a clinic to receive a single check for each

**E. Provider Numbers** (continued)

reimbursement period rather than multiple checks for individual providers. All providers within the group or clinic are required to be individually certified and would be issued either a billing or non-billing performing provider number.

**F. Temporary Provider Numbers**

HIRSP has issued temporary provider numbers to providers of HIRSP-covered services who were not Wisconsin Medicaid certified before August 1, 1998, and who have chosen not to become Wisconsin Medicaid certified. The temporary provider number is for use on HIRSP claims with service dates before August 1, 1998. HIRSP requires all claims to be submitted within 15 months of the date the service was provided.

**G. Voluntary Termination**

Providers who are Wisconsin Medicaid certified, other than those at skilled nursing facilities, may at any time terminate participation in Wisconsin Medicaid, and therefore, also HIRSP. Providers choosing to withdraw are required to give Wisconsin Medicaid a 30-day written notice of the decision and indicate the effective date of termination. Providers may not receive reimbursement for HIRSP on or after the effective date of termination, except on an urgent or emergent basis. If providers fail to specify an effective date in the notice of termination, Wisconsin Medicaid may terminate the provider effective on the date that it received the notice.

HIRSP providers certified as a skilled nursing facility may terminate participation in HIRSP upon advance written notice of not less than 30 days to HIRSP and to the facility's resident policyholders or their legal guardians. This notice is required to specify the effective date of termination.

## A. Covered Services

The Wisconsin Health Insurance Risk Sharing Plan (HIRSP) requires all covered services, which are listed in Section 6: Billing Requirements & Covered Services, to be medically necessary and appropriate, meet generally accepted standards of medical practice, and not be experimental. The services are required to be ordered or prescribed by a physician, with the exception of chiropractic services.

## B. Medically Necessary and Appropriate

"Medically necessary and appropriate" means a treatment, procedure, equipment, drug, device, or supply provided by a hospital, physician, or other health care provider that is required to identify or treat a policyholder's illness or injury and, as determined by HIRSP:

- Is appropriate with generally accepted standards of medical practice.
- Is not part of a plan of treatment that is considered to be experimental, investigational, or for research purposes in the diagnosis or treatment of an illness or injury.
- Does not exceed in scope, duration, or intensity the care that is needed to provide safe and adequate diagnosis or treatment.
- Does not exceed the most appropriate supply or level of services that can safely and effectively be provided.
- Is not primarily for the convenience of the policyholder, policyholder's immediate family, or caregiver. "Immediate family" includes the policyholder's spouse, children, parents, grandparents, brothers, sisters, and their spouses.

## C. Generally Accepted Standards of Medical Practice

"Generally accepted standards of medical practice" means a treatment, procedure, facility, equipment, drug, device, or supply for a specific illness or injury, which, after consulting available medical resources, HIRSP determines to be generally accepted by the United States medical community. The sources HIRSP consults may include any or all of, but are not limited to, the following:

- Independent consulting health care professionals.
- Official approvals of treatments or procedures by the American Medical Association.
- Medical literature such as the *New England Journal of Medicine,* the *Journal of the American Medical Association,* or *Lancet.*
- Position papers and guidelines of professional organizations and associations.
- Recent editions of commonly used medical specialty texts.
- Recent decisions of regulatory agencies such as the U.S. Food and Drug Administration.
- Assessment reports such as the Consensus Conference Statements released by the National Institutes of Health (NIH) and the Clinical Practice Guidelines published by the Agency for Health Care Policy and Research (HCPR).

## D. Experimental

"Experimental" means the use of any treatment, procedure, facility, equipment, drug, device or supply for a specific illness or injury that is experimental or investigative in nature. A

**D. Experimental** (continued)

service is considered experimental when HIRSP has determined that the medical community does not generally recognize the procedure or service as effective or proven for the condition for which it is being used. A service may be considered by HIRSP to be experimental in one setting or institution, but effective, proven, and nonexperimental in another depending on the experience, quality, and procedures used in a given institution. HIRSP resolves questions relative to the experimental or nonexperimental nature of a procedure based on:

- Judgment of the medical community.
- The extent to which Medicare and private health insurers recognize and cover a service.
- The current judgment of experts in the applicable medical specialty area.
- The sources identified under "Generally Accepted Standards of Medical Practice" in this section of the handbook.

## A. Policyholder Identification Number

Once the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) enrolls an individual, that person receives an identification card containing the policyholder's HIRSP identification number, HIRSP plan number, and other information. HIRSP discontinued using policyholder identification numbers with "9HI" prefixes effective July 1, 1998, and issued new policyholder identification numbers. HIRSP requires that these new policyholder numbers be used for all claims, adjustments, and customer service inquiries.

## B. Eligibility Verification

If a person claims HIRSP eligibility but does not present a HIRSP identification card at the time services are requested or provided, the provider may refuse to render any service or verify the policyholder's eligibility by contacting HIRSP Customer Service.

HIRSP will cover a newborn from delivery through the first two days after birth under a parent's HIRSP policy. After the second day, newborns are not covered under their parent's HIRSP policy. Services provided to the newborn will not be covered by HIRSP unless the newborn has his or her own HIRSP policy.

Below is a sample of the front and back of a HIRSP policyholder identification card. Policyholders are instructed to present their card to providers so they may verify HIRSP insurance.

**Front**

**HEALTH INSURANCE RISK SHARING PLAN**
**Identification Number**

XXXXXXXXXX PLAN: XX

NAME
RESIDENTIALADDRESS 1
RESIDENTIALADDRESS 2
RES CITY, RES STATE RES ZIP

**Prior Authorization Requirement - See Card Back**

**Back**

**IMPORTANT**

A Wisconsin Medicaid certified or certifiable provider must provide all services. Some services under this coverage require Prior Authorization. Your certified provider will assist you in obtaining Prior Authorization when required.

SEE YOUR POLICY FOR ADDITIONAL INFORMATION.

S.149.14 (4m) Wis. Stat. allows HIRSP to reduce reimbursement to providers for all eligible claims, which cannot be balance billed to the policyholder for amounts other than coinsurance and deductible for all covered expenses.

**FOR DEDICATED CUSTOMER SERVICE CALL:**

| **MADISON** | **TOLL-FREE** |
|---|---|
| (608) 221-4551 | 1-800-828-4777 |

**SEND ALL CLAIMS AND PRIOR AUTHORIZATION REQUESTS TO:**
WISCONSIN HEALTH INSURANCE RISK SHARING PLAN
6406 Bridge Road Ste. 18
Madison, WI 53784-0018

## B. Eligibility Verification (continued)

If providers have questions about an individual's HIRSP eligibility, they may telephone HIRSP Customer Service at (800) 828-4777 or (608) 221-4551. Provide the customer service representative with the policyholder's name, type of plan, and identification number. The representative will then verify the individual's HIRSP coverage.

## C. Limits on Policyholder Payment Responsibilities

Plan 1 policyholders are required to pay coinsurance and deductibles that vary in dollar amounts depending on whether they are enrolled in HIRSP Option A or Option B. The Remittance and Status (R/S) Reports that providers receive on their claims will show these coinsurance and deductible amounts. (See Section 8: Follow-Up to Claim Submission for more information about HIRSP R/S Reports and Appendix 5 for an example of a HIRSP R/S Report.)

Plan 2 policyholders do not pay coinsurance for HIRSP.

The policyholder is responsible for paying any required deductibles and coinsurance for services he or she receives.

HIRSP also sets maximum amounts for out-of-pocket medical expenses that a policyholder and a policyholder's family pay in one year. In these instances, HIRSP defines "family" as two or more of the following persons, or any combination thereof, who are insured under HIRSP: either or both spouses and all children of either spouse who are minors, unmarried, natural or adopted, including newborns from moment of birth.

Providers who have questions about a policyholder's coinsurance and deductible payment responsibilities may call HIRSP Customer Service at (800) 828-4777 or (608) 221-4551.

## D. Payment to Policyholder

Policyholders may submit claims and receive payment for HIRSP-covered services or assign to their provider HIRSP's benefits payment. Providers are not required to accept requests for assignment of benefits.

## E. Charging Policyholders for Covered Services

### Balance Billing

Section 149.14(4m), Wis. Stats., prohibits providers from balance billing HIRSP policyholders. Providers are required to accept HIRSP's payment as full payment for covered expenses; providers are prohibited from billing policyholders for the difference between the charge and the amount paid by HIRSP.

The provider may bill the policyholder in instances when both of the following statements are true:

- HIRSP does not cover a service.
- The provider informed the policyholder in advance that he or she will be responsible for payment.

Policyholders can be billed for coinsurance and deductibles.

## F. Right to Appeal

Either the provider or policyholder may request HIRSP to reconsider a claim payment decision.

If the provider disagrees with HIRSP's claim payment, the provider may submit an adjustment request form as instructed in this handbook. (See Appendix 4 in this handbook for instructions

**F. Right to Appeal** (continued)

and a copy of the HIRSP adjustment request forms for medical and drug claims.) HIRSP will evaluate the original processing decision and notify the provider of the outcome through an R/S Report.

If the policyholder disagrees with HIRSP's claim payment or denial, the policyholder may appeal HIRSP's claim payment or denial by filing an appeal. If the policyholder disagrees with the appeal decision, the policyholder may file a grievance. Providers may not file an appeal or grievance on behalf of a policyholder. The policyholder's contract contains information about how to file an appeal or grievance.

## A. Noncovered Services

As defined by the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) policy, services that are not covered are:

1. Routine exams, such as:
   - Asymptomatic physical exams.
   - HealthCheck screenings (e.g., well-child exams).
   - General dental care.
   - Annual physicals.
   - Routine vision exams to determine whether corrective lenses are needed or whether a prescription has changed.
   - Routine exams to determine whether hearing has changed.
2. Over-the-counter (OTC) medications, with the exception of insulin.
3. Treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital body defect, except as listed under Section 6: Billing Requirements & Covered Services.
4. Care that is primarily for custodial or domiciliary purposes that does not qualify as eligible services under Medicare.
5. Services or supplies, the provision of which is not within the scope of authorized practice of the institution or individual providing the services or supplies.
6. Expense incurred before policy effective date or after policy cancellation date.
7. Dental care, except as listed under Section 6: Billing Requirements & Covered Services.
8. Eyeglasses and contact lenses, except as listed under Section 6: Billing Requirements & Covered Services.
9. Hearing aids.
10. Injury or illness due to acts of war.
11. Services of blood donors and any fee for failure to replace blood.
12. Personal, nonmedical, or nonprescribed services or supplies provided by a hospital or nursing home.
13. Expense incurred for treatment of an injury or illness that is payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, liability insurance, or equivalent self-insurance policy.

## A. Noncovered Services (continued)

14. Expense incurred for treatment of an injury or illness that is covered by workers' compensation or employer's liability laws.

15. Expense incurred for treatment of an injury or illness that is payable under another policy of health care insurance, fixed indemnity, Medicare, or any other governmental program, except as otherwise provided by law. Treatment for an injury or illness is considered payable if the other policy or program would provide benefits for the treatment if all conditions it imposes for benefit payment are met.

16. Expense incurred for procedures or services that HIRSP determines are not medically necessary and appropriate.

17. Procedures and services that HIRSP determines are experimental (except drugs for the treatment of infection by the human immunodeficiency virus). The types of procedures that may fall into this category include but are not limited to:

    - New medical or biomedical technology.
    - Methods of treatment by diet or exercise.
    - New surgical methods or techniques.
    - Acupuncture or similar methods.
    - Transplants and implants of body organs, unless coverage is required by law, or the procedure is no longer considered experimental.

18. Procedures and services billed to the plan more than 15 months (428 days) after the policyholder received the service.

19. Administrative costs incurred in providing HIRSP with medical records to process claims, including, but not limited to, taxes, shipping and handling, and photocopying expenses.

## B. Policyholder Request for a Noncovered Service

On occasion, a policyholder may request or agree to receive a noncovered service instead of, or in addition to, a HIRSP-covered service. HIRSP will not reimburse for these services.

The charge for a noncovered service may be billed to the policyholder only if certain conditions are met prior to delivery of that service. The provider is required to explain to the policyholder prior to providing the service both of the following:

- HIRSP does not cover the service.
- The policyholder would be responsible for payment.

It is recommended the provider tell the policyholder this information orally and in writing. If the policyholder still requests the service, it then becomes a decision between the policyholder and the provider whether the service should be provided and how payment will be made.

## A. General Billing Requirements

This section of the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) handbook lists the major categories of HIRSP billing requirements and covered services. It does not contain an all-inclusive list of services that HIRSP covers. Providers should contact HIRSP Customer Service to verify that HIRSP covers a service if the service is not indicated in this section or in Section 5: Noncovered Services.

HIRSP follows most Wisconsin Medicaid claim submission requirements and many Wisconsin Medicaid policies and billing requirements. This section references the applicable Wisconsin Medicaid policies and materials providers should use to prepare and submit claims.

The following general claims submission requirements apply to all providers:

1. HIRSP pays the provider submitting the claim unless the claim indicates the policyholder should be paid. For HIRSP claims only, providers are required to use the following claim fields to indicate whom HIRSP should pay. HIRSP uses these fields for this purpose because HIRSP does not collect the Medicaid-related information usually reported in these fields. If HIRSP should send payment to the policyholder, providers should indicate that preference using the following claim fields:

   - **UB-92 Claim Form.** Item 53, Assignment of Benefits Certification Indicator. Indicate "N" if payment should go to the policyholder.

   - **HCFA 1500 Claim Form.** Element 27, Accept Assignment. If payment is to be made to the policyholder, indicate "No" in this element.

   - **HIRSP Drug Claim Form.** Element 31, Accept Assignment Yes/No. Leave this element blank or indicate "No" if payment is to be made to the policyholder. (See Appendix 3 about the HIRSP drug claim form.)

   - **Electronic Pharmacy Claims.** Use Facility Provider field. Indicate the policyholder name in this field if payment is to be made to the policyholder. If the provider leaves this field blank, HIRSP pays the provider. Do not use this field to identify a nursing home provider because HIRSP does not need nursing home information.

2. To identify the kind of service contained on a HCFA 1500 claim form, place Wisconsin Medicaid claim sort indicator values in the "Other" box on the top left side of the claim form. These values are listed in Wisconsin Medicaid service-specific handbooks.

3. The UB-92 and HCFA 1500 claim forms instruct providers to include the Wisconsin Medicaid recipient identification number, name, and address. When completing the form for a HIRSP policyholder, provide in those elements/items the HIRSP policyholder's identification number, name, and address. HIRSP policyholder identification numbers changed on July 1, 1998. All claims and adjustment requests submitted on or after July 1, 1998, are required to contain an identification number effective on or after that date.

4. Wisconsin Medicaid requires HealthCheck referrals for certain noncovered services. HIRSP does not cover screenings for HealthCheck, a program for Medicaid recipients under the age of 21. HIRSP does not require the HealthCheck referral as a condition of payment for a HIRSP-covered service.

## A. General Billing Requirements (continued)

5. Wisconsin Medicaid billing materials refer to copayment or copay. HIRSP uses coinsurance and deductibles instead of copayment (or copay).

6. HIRSP providers who choose not to become Wisconsin Medicaid certified have been issued a temporary provider number so that claims with service dates before August 1, 1998, may be paid. This temporary number is not valid for dates of service on or after August 1, 1998. Like all HIRSP claims, any claim for services provided before August 1, 1998, is required to be submitted to HIRSP within 15 months of the date the service was provided.

7. To receive reimbursement from HIRSP, all claims and adjustments for services rendered to policyholders are required to be submitted correct and complete to HIRSP within 15 months from the date of service.

8. At this time, HIRSP does not require prior authorization (PA). Do not use Wisconsin Medicaid's PA methodology for HIRSP.

## B. Covered Services

Beginning with subsection C below, this section of the HIRSP handbook outlines the services covered by HIRSP, including policies and benefit limitations and claim submission requirements that may be different from those used by Wisconsin Medicaid. HIRSP bases all covered services on the policyholder contract.

## C. Hospital Services

Within the limits described below, HIRSP covers the following medically necessary and appropriate hospital services:

- Room and board and any other covered inpatient and outpatient hospital services.
- In-hospital services for substance abuse (alcohol and other drug abuse) and mental or nervous disorders.
- Hospital inpatient and outpatient treatment of kidney disease, including dialysis, transplantation, and donor-related services.
- Hospital charges and anesthetics provided for covered dental services.

### Policies and Benefit Limitations

Providers are required to use Wisconsin Medicaid policies and benefit limitations outlined in Wisconsin Medicaid billing reference materials with the following exceptions:

1. Wisconsin Medicaid uses an external review organization (ERO) pre-admission review (PAR) to authorize elective inpatient hospital stays. HIRSP will not use the ERO. HIRSP providers should not contact the ERO about services for a HIRSP policyholder.

2. HIRSP is no longer requiring pre-admission review for hospital stays, but prior to payment HIRSP verifies that all hospital stays are medically necessary and appropriate as defined in Section 3: Criteria for Covered Services.

3. Inpatient services for substance abuse treatment are limited to 30 days during any one calendar year.

## C. Hospital Services (continued)

4. Inpatient services for treatment of mental or nervous disorders are limited to 60 days in any one calendar year.

5. Total benefit payment for kidney disease, including any other kidney disease benefits, are limited to $30,000 in any one calendar year.

6. Hospital charges and anesthetics provided for dental care are covered for dates of service on or after January 1, 1998, if the individual meets any of the following:

   - The individual is under the age of 5.
   - The individual has a chronic disability that is attributable to a mental and/or physical impairment that results in substantial functional limitation in an area of the individual's major life activity and the disability is likely to continue indefinitely.
   - The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

### Claim Submission Requirements

HIRSP requires the same data elements and revenue/procedure codes as required on Wisconsin Medicaid inpatient and outpatient claims with the following exceptions:

- HIRSP does not require hospitals to obtain PAR numbers from the ERO. Providers should leave blank the items on the claim form that request PAR numbers.
- On the UB-92 form, providers are required to indicate "HIRSP" in item 50 and their Wisconsin Medicaid provider number in item 51.

## D. Basic Medical-Surgical Services

Basic medical-surgical services include:

- In-hospital and out-of-hospital medical and surgical services.
- Diagnostic services.
- Anesthesia services.
- Consultation services.

### Policies and Benefit Limitations

Providers are required to use Wisconsin Medicaid policies and benefit limitations with the following exceptions:

1. Sterilizations do not require a consent form.

2. Hysterectomies do not require a policyholder to complete the Acknowledgment of Receipt of Hysterectomy Information Form.

## D. Basic Medical-Surgical Services (continued)

3. HIRSP reviews podiatric services for medical necessity. HIRSP will ***not*** adhere to the following podiatric restrictions:

   - Wisconsin Medicaid limits debridements of mycotic conditions and nails to six a year.
   - Wisconsin Medicaid limits routine foot care procedures to once every 61 days and to certain diagnoses.

4. Total benefit payment for kidney disease, including any other kidney disease benefits, is limited to $30,000 in any one calendar year.

5. HIRSP does not use Wisconsin Medicaid's Second Surgical Opinion Program.

6. A diabetic outpatient self-management education program is covered if all of the following apply:

   - A Wisconsin Medicaid-certified provider provides it.
   - It is designed to teach diabetic patients and their immediate families to understand the diabetic disease process, to manage the daily diabetic therapy, and to avoid frequent hospital confinements and complications.
   - It meets any standards by which the state certifies and approves such programs.
   - It is not an education program mainly for the purpose of weight reduction.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims, with the exception that providers are required to use the following procedure codes for diabetes education:

- 99071, type of service (TOS) "1," for diabetic educational supplies.
- 99078, TOS "1," for diabetic education.

## E. Laboratory and Radiology Services

### Policies and Benefit Limitations

Providers are required to use Wisconsin Medicaid policies and benefit limitations outlined in Wisconsin Medicaid service-specific handbooks and in Wisconsin Medicaid Updates with the following exceptions:

1. Blood lead test coverage is limited to policyholders under 6 years of age.

2. Routine mammographies are covered with the following restrictions:

   - Two routine mammographies for women age 45 through 49 provided both conditions are met:

     - The woman has not had a mammography within two years before each mammography is performed.

**E. Laboratory and Radiology Services** (continued)

- Prior to obtaining coverage under HIRSP, the woman had not obtained one or more mammographies while between the ages of 45 through 49. Benefits will be reduced to the extent that any prior mammographies have been obtained.

- One routine mammography per calendar year for women age 50 and over.

3. Wisconsin Medicaid's laboratory service billing requirements under the federal Deficit Reduction Act (DEFRA) do not apply to HIRSP.

**Claim Submission Requirements**
HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims.

**F. Durable Medical Equipment**

Durable medical equipment (DME) also includes orthotics and prosthetics.

**Policies and Benefit Limitations**
HIRSP covers the following DME described below:

1. The purchase or rental of DME (whichever HIRSP determines to be most cost-effective).

2. Installation, use, or purchase of one insulin infusion pump in any calendar year and only after the policyholder has used the pump for 30 days.

3. Purchase of temporary and permanent prosthetics with documentation showing they are medically necessary and appropriate.

Internal prostheses (e.g., breast and lens) are covered surgical procedures under medical services; they should not be billed as DME.

**Claim Submission Requirements**
HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims.

**G. Disposable Medical Supplies**

**Policies and Benefit Limitations**
HIRSP covers medically necessary and appropriate disposable medical supplies (DMS).

**Claim Submission Requirements**
HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims.

**H. Dental and Oral Surgery Services**

**Policies and Benefit Limitations**
HIRSP covers the following services:

1. Oral surgery for partially or completely unerupted, impacted teeth.

2. Oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth.

**H. Dental and Oral Surgery Services** (continued)

3. Prescribed intraoral splint therapy devices.

4. Diagnostic procedures and medically necessary and appropriate surgical or nonsurgical treatment for the correction of temporomandibular dysfunctions for dates of service on or after January 1, 1998, if all of the following conditions are met:

   - The condition is caused by congenital, developmental, or acquired deformity, disease, or injury.
   - The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition, under the accepted standards of the profession of the health care provider rendering the service.
   - The purpose of the procedure or device is to control or eliminate infection, pain, disease, or dysfunction.

5. Hospital or ambulatory surgical center charges and anesthetics provided for dental care for dates of service on or after January 1, 1998, if the individual meets any of the following:

   - The individual is under the age of 5.
   - The individual has a chronic disability that is attributable to a mental and/or physical impairment that results in substantial functional limitation in a major life activity and the disability is likely to continue indefinitely.
   - The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims with the following exceptions:

- HIRSP covers nonsurgical temporomandibular dysfunction. Use the appropriate *Current Procedural Terminology* (CPT) procedure codes for the following generally accepted nonsurgical temporomandibular services:
  - Short term medication.
  - Home therapy.
  - Intraoral splint therapy. Use D7899, TOS "G."
  - Physical therapy, including correction of myofunctional habits.
  - Relaxation or stress management techniques.
  - Psychological evaluation or counseling.

## I. Therapy Services

Therapy services include physical therapy, occupational therapy, and speech therapy.

### Policies and Benefit Limitations

HIRSP covers medically necessary and appropriate services performed by a Wisconsin Medicaid-certified physical therapist, occupational therapist, speech and language pathologist, certified occupational therapy assistant, and physical therapy assistant.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims.

## J. Ambulance Services

### Policies and Benefit Limitations

HIRSP covers medically necessary transportation provided by a licensed ambulance service to the nearest Wisconsin Medicaid-certified hospital or skilled nursing care facility required to treat the condition. Transportation must be provided by a licensed ambulance service, including air, water, or land ambulance.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims.

## K. Chiropractic Services

### Policies and Benefit Limitations

HIRSP covers medically necessary and appropriate chiropractic services comparable to services HIRSP covers for physicians and osteopaths. The service provided by the chiropractor is required to be within the scope of the chiropractor's professional license. Policyholders do not need a referral from a physician to see a chiropractor.

### Claim Submission Requirements

HIRSP requires the same elements as required on Wisconsin Medicaid claims. Chiropractic services can be billed by using:

- Wisconsin Medicaid procedure code W9010 for manipulations.
- CPT codes (TOS "1" or "9") that best describe the service provided.

## L. Vision Services

### Policies and Benefit Limitations

HIRSP covers the following vision services:

1. Diagnostic vision exams that are performed for medical reasons. For example, an exam to determine the reason for sudden, unexplained vision loss would be covered.
2. The initial purchase of eyeglasses or contact lenses for aphakia and keratoconus and following cataract surgery. Other than for these conditions, HIRSP does not cover eyeglasses or contacts.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims with one exception. Because HIRSP does not participate in the State Purchase Eyeglass Contract (SPEC), procedure codes used for HIRSP differ from the codes used by Wisconsin Medicaid.

## L. Vision Services (continued)

Providers are required to bill HIRSP-covered vision services using HCFA Common Procedure Coding System (HCPCS) procedure codes V2020 through V2799, TOS "J," listed under "Vision Care Services, Procedure Codes, and Copayment Table" in Part R, the Wisconsin Medicaid vision care handbook.

## M. Audiology and Hearing Services

### Policies and Benefit Limitations

HIRSP covers hearing exams that are performed to diagnose a medical problem, such as an exam to determine the reason for sudden, unexplained hearing loss.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims.

## N. Skilled Nursing Care

### Policies and Benefit Limitations

HIRSP covers the following skilled nursing home services:

1. HIRSP pays skilled nursing facility (SNF) benefits for up to 30 days of each SNF stay. All confinements are required to be upon the specific recommendation and under the supervision of a physician. A covered stay is one of the following:

   - Admission is at least 60 days after the policyholder was last confined in an SNF for the injury or illness that caused the prior confinement.

   - Admission in an SNF is not related to a cause of a previous confinement.

   If a policyholder is enrolled in HIRSP Plan 2, HIRSP does not pay for more than a total of 120 days in an SNF in any one calendar year. The expense is required to be Medicare reimbursable.

2. Unlike Wisconsin Medicaid, the Bureau of Quality Assurance (BQA) does not review HIRSP policyholders to determine the level of care. HIRSP reviews nursing home claims for medical necessity of an SNF stay.

3. The nursing home daily reimbursement rate includes most services, supplies, and equipment provided by the nursing home. Certain supplies, equipment, and services are not included in this daily rate. To be paid, these services are required to be HIRSP-covered services and are required to be medically necessary and appropriate. Providers are required to use the policies and limitations outlined under each type of covered service listed in Section 6: Billing Requirements & Covered Services to identify HIRSP-covered services. These services should be billed using the claim forms and procedure codes used for Wisconsin Medicaid, unless otherwise instructed.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims with the following exceptions:

- Unlike Wisconsin Medicaid, HIRSP claims do not have patient liability.

- HIRSP only covers nursing home stays at an SNF and at a skilled level of care. No other type of nursing home stay (such as intermediate care) is covered.

## O. Home Care and Hospice

### Home Care Benefits

HIRSP pays medically necessary home health care and hospice care services provided to policyholders in their home. Covered expenses are required to be provided by, or coordinated by, a home health care agency. A home health care agency is engaged primarily in providing skilled nursing services to the policyholder at the policyholder's place of residence. Covered services include the following:

1. Part-time intermittent home nursing care by or under the supervision of a registered nurse.

2. Part-time or intermittent home health aide services that are medically necessary and appropriate as part of the home care plan that consists solely of caring for the patient. Such services are required to be under the supervision of a registered nurse.

3. Physical, respiratory, occupational, or speech therapy.

4. Nutrition counseling provided by or under the supervision of a physician, registered nurse, licensed pharmacist, or other licensed provider. Such services are required to be medically necessary and appropriate as part of the home care plan.

5. The evaluation of the need for and development of a plan by providers who may be a registered nurse, physician assistant, or nurse practitioner for home care when approved or required by the attending physician.

6. Medical supplies, drugs, and medications prescribed by providers and laboratory services by or on behalf of a hospital, if necessary, under the home care plan. The above items are covered expenses to the same extent as if the policyholder had been hospitalized.

### Payment Criteria

To be considered for payment, the covered services listed above are required to meet all of the following criteria:

- The services are required to be included under a plan of home care that is established and approved in writing and is revised at least every two months by the attending physician, unless the attending physician determines that a longer interval between reviews is sufficient. If there was hospitalization immediately prior to the start of home care, the home care plan is required to be initially approved by the physician who was the primary provider of services during hospitalization.

- The attending physician certifies that hospitalization or confinement in an SNF would be required if home health care was not provided.

- Necessary care and treatment are not available from the immediate family or other persons residing with the patient without causing undue hardship. Immediate family includes the policyholder's spouse, children, parents, grandparents, brothers, sisters, and their spouses.

## O. Home Care and Hospice (continued)

### Benefit Limitations

Home health care benefits are limited to:

- 40 home care visits in a calendar year for Plan 1 policyholders.
- 365 home care visits in a calendar year, in combination with the home care visits Medicare has covered, for Plan 2 policyholders.

Hospice services count toward the home health care benefit limits.

Four consecutive hours of home care in a 24-hour period or each visit by a member of a home care team is considered to be one home care visit.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims with the following exceptions:

- Hospice services provided in the home are counted toward HIRSP home care benefit limitations; use home care billing materials, procedure codes, etc. HIRSP does not use Wisconsin Medicaid's hospice policies, requirements, or procedure codes.
- Procedure code 99401, TOS "H," is for nutrition counseling.
- Procedure code W9922, TOS "1," is for home health social worker services.

## P. Substance Abuse and Mental Health Services

### Inpatient Policies and Benefit Limitations

HIRSP pays inpatient services provided by a physician, or under the supervision of or on referral from a physician, for substance abuse and mental and nervous disorders. Inpatient services are provided to a patient in a hospital or any facility for which state law mandates benefits be paid. This includes psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation care.

Benefits are limited to:

- 30 days per calendar year for drug and alcoholism treatment.
- 60 days per calendar year for mental and nervous disorder treatment.
- 60 days per calendar year if the stay is for both substance abuse and mental health services.

### Outpatient Policies and Benefit Limitations

HIRSP pays outpatient services for substance abuse and mental and nervous disorders provided:

- By a physician.
- Under the supervision of or on referral from a physician, including services provided by Wisconsin Medicaid-certified psychiatric nurses.

## P. Substance Abuse and Mental Health Services (continued)

Outpatient services are nonresidential services provided to the policyholder or, if to enhance the policyholder's treatment, to the policyholder's immediate family. Services include partial hospitalization services, prescribed drugs, convulsive therapy, psychotherapy, and psychological testing.

Benefits are limited to $3,000 per calendar year, inclusive of all outpatient substance abuse and mental and nervous disorder services provided. The first $500 of eligible expenses is not subject to HIRSP deductible and coinsurance. Covered expenses exceeding the first $500 are subject to the deductible and coinsurance.

### Transitional Treatment Policies and Benefit Limitations

HIRSP pays the expense incurred for transitional treatment. Transitional treatment of substance abuse and nervous and mental disorders is:

- More intensive than outpatient services.
- Less restrictive than inpatient hospital services.

HIRSP pays the expense incurred for transitional services, which include the following levels of service:

- Certified adult mental health day treatment program defined in HFS 61.75, Wis. Admin. Code.
- Certified child/adolescent mental health day treatment program as defined in HFS 40.03(15), Wis. Admin. Code.
- Certified substance abuse day treatment program as defined in HFS 61.61, Wis. Admin. Code.
- Certified community support program as defined in HFS 61.61, Wis. Admin. Code.
- Certified residential substance abuse treatment program as defined in HFS 61.60, Wis. Admin. Code.
- Intensive outpatient program for substance abuse as outlined in criteria established by the American Society of Addiction Medicine.

Benefits are limited to $3,000 per calendar year. These services are not subject to deductible and coinsurance.

### Claim Submission Requirements

HIRSP requires the same elements and procedure codes as required on Wisconsin Medicaid claims with one exception. Providers bill transitional treatment (substance abuse day treatment and mental health day treatment) on the UB-92 form. To accurately exempt claims for transitional treatment from HIRSP coinsurance and deductibles, providers are required to indicate condition code 41 on each transitional treatment claim.

## Q. Drug Services

HIRSP-covered drug services include prescription drugs and insulin.

### Policies and Benefit Limitations

Providers are required to use Wisconsin Medicaid's policies and benefit limitations outlined in Wisconsin Medicaid billing materials for prescription drugs and insulin with the following exceptions:

1. HIRSP may limit coverage on certain drugs based on medical necessity.

2. A diabetic outpatient self-management education program is payable if it meets all of the following:

   - Is provided by a physician, a registered nurse, a pharmacist, or other Wisconsin Medicaid-certified provider.

   - Is designed to teach diabetic patients and their immediate families to understand the diabetic disease process, to manage the daily diabetic therapy, and to avoid frequent hospital confinements and complications.

   - Meets any standards by which the state certifies and approves such programs.

   - Is not an education program mainly for the purpose of weight reduction.

### Claim Submission Requirements

Providers submitting drugs on paper claim forms are required to use the HIRSP drug claim form, which is similar to the Wisconsin Medicaid drug claim form. (See Appendix 3 for an example of the HIRSP drug claim form.)

All compound drugs are required to be submitted on paper claims with the compound's component drugs identified.

Providers are required to send the completed claim form to HIRSP's mailing address as listed under "Mailing Address for Paper Claims" in Section 7: Billing Information.

To complete the HIRSP drug claim form, follow Wisconsin Medicaid paper claim submission requirements for drug claims with one exception. Element 31, Accept Assignment, is required to be "Yes" if the provider wants HIRSP to send payment to the provider. If this element is blank or is "No," HIRSP sends payment to the policyholder. All other instructions in the Wisconsin Medicaid pharmacy handbook apply.

On electronic pharmacy claims, providers are required to indicate the policyholder name in the facility provider field if the provider wants payment sent directly to the policyholder. Leave this field blank if payment is to be sent to the provider. Do not use this element to identify a nursing home.

HIRSP does not limit the number of pharmacy claims providers may submit per policyholder, per week.

## A. Claim Submittal and Processing

### Submitting Claims

Providers may submit claims to the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) only after they provide the services. Whenever possible, all charges relating to a date of service or month of service should be billed on a single claim to avoid excess paperwork.

It is generally recommended that providers bill at least on a monthly basis to allow the maximum time available for filing/refiling within the mandatory 15-month claim submission deadline.

### Paper Claims

Individuals submitting claims are required to use HIRSP's claim forms, which include the UB-92, national HCFA 1500, and HIRSP provider drug claim form. To assist HIRSP in correctly processing and paying claims, providers should enter claim data clearly with a typewriter or computer printer. HIRSP can process and pay a claim correctly only if providers supply all data accurately and completely in a legible manner on the face of the claim form. HIRSP denies any claim that is illegible or improperly completed.

Wisconsin Medicaid billing materials instruct providers about the appropriate claim forms. HIRSP uses the same claim forms as Wisconsin Medicaid, except HIRSP has its own provider drug claim form. (Please see Appendix 3 for information on the HIRSP provider drug claim form.)

Providers are required to mail HIRSP claims separately from Wisconsin Medicaid claims. Please use HIRSP's address indicated under "Mailing Address for Paper Claims" in this section of the handbook.

### Electronic Claims

As an alternative to submission of paper claims, HIRSP can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. All provider types may submit claims electronically. All claims that providers submit are subject to the same legal requirements as paper claims.

Electronic claim submission eliminates manual handling of claims, reducing errors and allowing faster turnaround time. Providers submitting electronically usually reduce their claim submission errors. As with paper claims, electronically submitted claims can be processed and paid correctly only if all data supplied is accurate and complete. Providers are responsible for the accuracy of all data submitted via electronic claims.

Providers interested in electronic claim submission should contact HIRSP's Electronic Media Claims (EMC) Department either in writing or by telephone for specifications required to allow billing services and providers to transmit information directly. Written requests for information should be made to:

EMC Department
HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

Providers who are interested in electronic claims submission can call HIRSP's EMC Department at (608) 221-4746.

## B. Plan 2 Claims

Providers are required to submit claims for Plan 2 policyholders first to Medicare Part A or Medicare Part B. Medicare carriers will not automatically forward claims (e.g., a "crossover" claim via magnetic tape) to HIRSP. HIRSP accepts crossover claims on paper with the Explanation of Medicare Benefits (EOMB) attached. When submitting a paper crossover claim, providers are required to follow all HIRSP billing requirements.

The provider may submit the claim directly to HIRSP if both of the following apply:

- The provider knows that a service is not a Medicare benefit.
- The claim is for a Plan 2 policyholder.

To indicate that the service is not a Medicare benefit, use the appropriate Medicare disclaimer code for Wisconsin Medicaid on the claim form.

No service reimbursed by Medicare under a global reimbursement policy may be billed separately to HIRSP. If Medicare determines a service is not medically necessary, HIRSP will also deny the service. Medicare claims denied for provider billing error should be corrected and resubmitted to Medicare.

If Medicare reconsiders a previous payment, HIRSP may change its reimbursement. If there is a Medicare allowed amount but no previous HIRSP reimbursement, the provider should submit copies of both the original and revised Medicare EOMBs attached to the crossover claim. If a previous HIRSP reimbursement needs to be corrected, the provider should submit copies of both the original and revised EOMBs attached to an adjustment request form. (Please see Appendix 4 for information on the HIRSP adjustment request form.)

## C. Provider Responsible for Filing Accurate Claims

Providers are responsible for the accuracy, truthfulness, and completeness of all claims submitted, whether these claims are submitted on paper or electronic media by the provider or by a billing agent. HIRSP is not responsible for costs associated with the preparation or submission of either paper or electronic claims from a provider or an entity acting on behalf of a provider. If an outside agency or service prepares or submits claims, the provider is responsible for charges related to this service. The charges a provider pays for outside claim preparation cannot be tied in any way to the amount of HIRSP payments, nor may these charges reflect the actual HIRSP reimbursement.

## D. Obtaining Claim Forms

HIRSP's drug claim form for providers may be obtained from HIRSP by sending written requests to:

Form Reorder
HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

Please see Appendix 3 for information on the provider drug claim form.

Providers who bill HIRSP using either the UB-92 or national HCFA 1500 claim form are

## D. Obtaining Claim Forms (continued)

required to purchase them from commercial vendors. For the UB-92 form, one supplier is:

Standard Register
PO Box 6248
Madison, WI 53716
(608) 222-4131

One supplier of the HCFA 1500 claim form is:

Lakeside Association Services
PO Box 1109
Madison, WI 53701
(608) 257-6781
(800) 362-9080

## E. Mailing Address for Paper Claims

Completed claims are required to be mailed to the following address:

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

## F. Reimbursement

HIRSP reimburses providers and policyholders for covered services at HIRSP's reimbursement rates. HIRSP will subtract policyholder coinsurance, deductible, and third-party insurance payment amounts from HIRSP's allowed amount to determine HIRSP's payment. Providers, except for pharmacists, should bill their usual and customary charge for any particular service rendered, even if HIRSP's actual reimbursement rate is less.

### Outpatient Hospital Reimbursement

For outpatient hospital UB-92 claims, HIRSP generally pays at a rate per visit. Some services are not included in this rate, and providers are required to bill separately on the HIRSP drug claim form or HCFA 1500 form. This reimbursement methodology may result in an allowed amount and paid amount greater than billed charges. As a result, the HIRSP deductible and coinsurance can be greater than the billed amount.

### Inpatient Hospital Reimbursement

For inpatient hospital UB-92 claims, HIRSP generally pays at a rate per stay based on diagnosis-related group (DRG). Some services are not included in this rate, and providers are required to bill separately on the HIRSP drug claim form or HCFA 1500 form. This reimbursement methodology may result in an allowed amount and paid amount greater than billed charges. As a result, the HIRSP deductible and coinsurance can be greater than the billed amount.

### Nursing Home Reimbursement

For nursing home claims, HIRSP generally pays at a rate per day. This includes the same ancillary charges as Wisconsin Medicaid.

### Pharmacy Reimbursement

Pharmacists are required to bill Medicaid allowed charges, not usual and customary charges. To determine the allowed charge to bill HIRSP directly or to collect from the policyholder,

## F. Reimbursement (continued)

use the following formulas and dispensing fees:

- **Generic Drugs on the Maximum Allowable Cost (MAC) List**
  MAC + Dispensing Fee. (MAC lists are updated quarterly in Part J, the Wisconsin Medicaid pharmacy handbook, replacement pages).

- **Brand Name Drugs and Generic Drugs not on the MAC List**
  Average Wholesale Price (AWP) ✎ 10% + Dispensing Fee.

- **Dispensing Fees**
  Traditional Dispensing Fee $4.38
  Unit Dose Dispensing Fee $6.44
  These fees are equal to Wisconsin Medicaid's dispensing fee minus $0.50.

### Reimbursement for Other Services

For all other services, HIRSP generally pays at a procedure code-specific rate per service. HIRSP's allowed amount is the lesser of billed charges or HIRSP's rate per service.

### Payments for Medicare Coinsurance and Deductible

Consistent with HIRSP's reimbursement methods, HIRSP pays the Medicare deductible in full and pays up to the Medicare coinsurance amount.

### Remittance and Status Reports

With each payment, providers receive a Remittance and Status (R/S) Report from HIRSP that explains the status of all processed claims, adjustments, and denials for the period specified. Explanation of benefit (EOB) codes on the R/S Reports identify all payment reductions.

## G. Reimbursement Examples

The following examples illustrate HIRSP's reimbursement methodologies:

| | | Outpatient Hospital | | Inpatient Hospital | | Nursing Home Claims | | Pharmacy Services | | All Other Services | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A. | Provider's charge for a service | $100 | $300 | $3,000 | $3,000 | $500 | $500 | $50 | $50 | $50 | $50 |
| B. | HIRSP rate | $150 | $150 | $3,500 | $2,000 | $600 | $300 | $60 | $40 | $60 | $40 |
| C. | HIRSP-allowed amount | $150 | $150 | $3,500 | $2,000 | $500 | $300 | $50 | $40 | $50 | $40 |
| D. | HIRSP deductible | $100 | $0 | $1,000 | $0 | $100 | $0 | $30 | $0 | $30 | $0 |
| E. | Allowed amount minus deductible (C - D) | $50 | $150 | $2,500 | $2,000 | $400 | $300 | $20 | $40 | $20 | $40 |
| F. | HIRSP coinsurance (20% of E) | $10 | $30 | $500 | $400 | $80 | $60 | $4 | $8 | $4 | $8 |
| G. | HIRSP payment (E - F) | $40 | $120 | $2,000 | $1,600 | $320 | $240 | $16 | $32 | $16 | $32 |

## H. Balance Billing

Providers are required to accept the HIRSP-allowed amount as payment in full for covered expenses. Providers cannot charge policyholders for the difference between the charge for the service and the HIRSP-allowed amount. Providers may only charge policyholders for coinsurance and deductible amounts applied to claims. The R/S Report shows these amounts.

## I. Release of Billing Information

Providers are required to notify HIRSP when an attorney or an insurance adjustor requests billing or medical information related to charges paid by HIRSP. The request may be for personal injury claims, workers' compensation claims, notice of intent to file a lien, transfer by affidavit, or probate claims for which HIRSP benefit payments may be recovered. This is an effective tool in allowing HIRSP to identify benefit recovery opportunities.

Requests by interested parties should be directed to:

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

If a provider receives an attorney's request for a billing statement, it is required to be accompanied by a proper authorization for release from the policyholder. In this case, the provider can furnish the requested material so long as it is prominently marked "BILLED TO HIRSP" or "TO BE BILLED TO HIRSP."

The person requesting the billing information is required to notify HIRSP if the request is for:

- Personal injury claim.
- Workers' compensation claim.
- Notice of intent to file a lien.
- Transfer by affidavit.

The requestor is required to provide HIRSP:

- The policyholder's name and HIRSP identification number.
- Name and address of person making the request.
- Date(s) of service.
- Information about the incident leading to the medical service, if available, for requests regarding personal injury and workers' compensation claims.

A photocopy of the request or release with notations is sufficient for notification.

**I. Release of Billing Information**
(continued)

## A. Response to Claim Submission

A claim submitted to the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) for payment appears on the Remittance and Status (R/S) Report as a payment, as pending, or as a denial. In most cases, these claims will appear on the R/S Report within 30 days of the date that HIRSP received the claim/adjustment request. A claim/adjustment request that has pended more than 30 days since its receipt by HIRSP appears on the last R/S Report of each month. This notifies the ***payee*** that the claim is processing and that no further action is required, thus eliminating the need to submit "tracers" or "second billings." However, if a claim/adjustment request appears as pending for an unusual length of time, a telephone or written inquiry should be made to HIRSP Customer Service regarding the status of the claim. Call Customer Service at (800) 828-4777 or (608) 221-4551.

If the policyholder is a claim's payee, that claim will not appear on the provider's R/S Report even if the provider submitted the claim on the policyholder's behalf.

Providers should call HIRSP Customer Service at (800) 828-4777 or (608) 221-4551 if a claim does not appear on a payee's R/S Report within 30 days of the date of submission. Providers should be prepared to resubmit a copy of the original claim to HIRSP through normal processing channels if Customer Service indicates such action is appropriate.

## B. Remittance and Status Reports

The HIRSP R/S Report is nearly identical to the Wisconsin Medicaid R/S Report in format and content. Information pertaining to the Wisconsin Medicaid R/S Report may be found in Part A, the Wisconsin Medicaid all-provider handbook. An example of the HIRSP R/S Report is in Appendix 5. The following items are different on the HIRSP R/S Report:

- The R/S Report will reference the HIRSP address and phone number.
- Since policyholders will also receive this R/S Report, HIRSP is changing the field tag of "Provider Number" in the report header to "Payment Identification Number."
- A new column (to the right of "Total Allowed") with the field header "Ded" displays the amount of each claim that was applied to the policyholder's deductible.
- The "Copay" column is removed. Copay does not apply in HIRSP.
- A new column (to the right of "Ded") with the field header "Coins" displays the amount of each claim that was applied to coinsurance.
- The "Other Deducted Charges" column will continue to display the amount of the claim that was paid by other insurance.
- The final field header of "Net 1099 Amount" is changed to "Net Amount."
- HIRSP will not provide tape R/S Reports.

## C. Follow-Up Procedures Required of the Provider

### Verify Accuracy of the Remittance and Status Report

An important aspect of the claim submission process is the follow-up that should occur when the provider receives the R/S Report. Providers are required to verify the information for accuracy by comparing it to the claim(s) submitted to ensure that HIRSP processed all elements of the claim(s) as submitted. Providers are required to identify and correct any discrepancy that may affect the way HIRSP processed the claim. The Explanation of

## C. Follow-Up Procedures Required of the Provider (continued)

Benefits (EOB) code(s) that appears in the far right column of the R/S Report explains either why HIRSP paid or denied the claim. Providers may use this information to determine what action, if any, should be taken to obtain payment. In general, providers are required to:

- Correct and resubmit rejected claims.
- Adjust claims that result in erroneous/partial payment.

If the policyholder is a claim's payee, that claim will not appear on the provider's R/S Report even if the provider submitted the claim on the policyholder's behalf.

### Adjustments to Paid Claims

If after review of the R/S Report the provider determines a claim needs adjustment, the provider may begin reconsideration of the paid or partially paid claim by submitting to HIRSP an adjustment request form. If the provider believes HIRSP inappropriately denied the claim, providers are required to submit a new claim instead of an adjustment request. (Please see Appendix 4 for a sample of the adjustment request form and completion instructions.) This form is used to supply additional information that may affect the amount of reimbursement or to correct a billing or processing error. All adjustments and resubmittals are required to be filed within 15 months of the date of service.

HIRSP indicates on an R/S Report what payment adjustment it is making. If the provider still believes an error has occurred and the adjustment has not been satisfactorily resolved, the provider may elect to readjust the claim or call HIRSP Customer Service at (800) 828-4777 or (608) 221-4551.

Although the payee initiates most adjustment requests, HIRSP may initiate adjustment at any time if a claim was paid in error.

### Return of Overpayments

Providers are required to return any overpayment within 30 days of the date of discovery. Providers may request that HIRSP deduct the excess payment from future HIRSP reimbursement amounts by submitting to HIRSP an adjustment request form. They should use the form to indicate the cause and source of the overpayment and the amount. (Please see Appendix 4 for a sample of the adjustment request form and completion instructions.)

Providers should use the adjustment request form for returning duplicate payments or overpayments because:

- A cash refund does not provide documentation for the provider's records as an adjustment request does.
- The provider may be required to submit proof of the refund at a later date.
- A cash refund does not allow the provider to adjust the claim further if the provider learns of an additional reason for adjustment.

## D. Reviews and Audits

The Department of Health and Family Services (DHFS) or HIRSP may periodically review provider records related to HIRSP claims, subject only to restrictions of law. This includes the right to inspect, review, audit, and reproduce the records. Providers are required to

**D. Reviews and Audits** (continued)

permit easy access to any requested HIRSP-related records, whether in written, electronic, or micrographic form.

The DHFS may withhold HIRSP provider payments, in whole or in part, as the result of any review or audit. HIRSP payments may be withheld on receipt of reliable evidence that fraud or willful misrepresentation exists. "Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

# Appendices

# Appendix 1
# Contact Information

Providers are required to contact the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) at the address provided below in the following instances:

- Inquiries regarding benefits or claims.
- Orders for drug claim forms.
- Claim submissions.
- Referral of policy questions related to liability claims.

For any of these items, contact HIRSP Customer Service at the following address and telephone numbers:

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018
(800) 828-4777 or (608) 221-4551

Providers are required to mail completed claims to the following address:

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

Requests for Wisconsin Medicaid certification, changes in status, or questions about certification may be directed to the Wisconsin Medicaid fiscal agent:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006
(800) 947-9627 or (608) 221-9883

Providers who are interested in electronic claims submission can contact HIRSP's Electronic Media Claims Department:

EMC Department
HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018
(608) 221-4746

Providers who bill HIRSP utilizing either the UB-92 or national HCFA 1500 claim form are required to purchase them from commercial vendors. For the UB-92 form, one supplier is:

Standard Register
PO Box 6248
Madison, WI 53716
(608) 222-4131

One supplier of the HCFA 1500 claim form is:

Lakeside Association Services
PO Box 1109
Madison, WI 53701
(608) 257-6781
(800) 362-9080

# Appendix 2
# Provider Inquiry Form

**Please photocopy the next two pages (45-46) and complete this side of form.**

_____ **(Provider Name)** **Provider #** _____

_____ **(Contact Person)** **Phone #** _____

_____ **(Street Address)**

_____ **(City, State, ZIP)**

**NOTE:** Telephone HIRSP at (800) 828-4777 or (608) 221-4551 instead of written correspondence, except when:
- A HIRSP Customer Service representative has advised you to write.
- The inquiry involves extensive documentation or research.

**Claim/Adjustment in Question: (Attach a copy of the claim or adjustment and the Remittance and Status [R/S] Report page.)**

**Policyholder Name:** _____

**Policyholder Identification Number:** _____

**Claim Number:** _____

**Date(s) of Service:** _____

**Amount Billed:** $ _____ **R/S Report Date:** _____

**Explanation of Benefits (EOB) Code(s):** _____

**Other:** _____

**Reason for Inquiry**

- Questioning claim denial that HIRSP Customer Service could not assist with (please explain below).
- HIRSP Customer Service representative advised writing (please explain below).
- Inquiry involves extensive documentation or research (please explain below).
- Other (briefly explain the situation in question): _____

_____

_____

_____

**Provider Signature** **Date**

Retain a copy of this inquiry for your records and submit to Customer Service, HIRSP, Suite 18, 6406 Bridge Road, Madison, WI 53784-0018.

(over)

# HIRSP's Response

(Leave blank, to be completed by HIRSP.)

## Information Needed

In order to complete research on your inquiry, HIRSP needs the following information. Please send the information to HIRSP, along with copies of all materials originally sent to HIRSP.

- Provider name and eight-digit provider number.
- Policyholder name and 10-digit HIRSP identification number.
- Copy of any previous response related to the inquiry.
- Date of service.
- Amount billed.
- R/S Report copy. Do not send original R/S.
- Copy of the claim in question.
- Copy of the Medicare Explanation of Medicare Benefits (EOMB).
- Copy of the adjustment in question.
- Record of treatment dates.
- Other. _____

_____

_____

_____

## Resolution of Inquiry

- Claim/adjustment was resubmitted by HIRSP through normal processing channels.
- Claim/adjustment was resubmitted by HIRSP with special instructions for processing.
- Claim has been forwarded for consultant review.
- Claim was denied correctly. Review _____ and call HIRSP if you need more information.
- Claim/adjustment was paid on your R/S Report dated _____
- Claim/adjustment was denied on your R/S Report dated _____
- Resubmit the claim/adjustment through normal processing channels.
- This claim exceeds the 15-month filing deadline.
- Other: _____

_____

_____

_____

Customer Service Control Number Customer Service Representative Signature Date

# Appendix 3
# Provider Drug Claim Form

On the following page (48) is a sample of the HIRSP provider drug claim form. Instructions for completing this form can be found in Part J, the Wisconsin Medicaid pharmacy handbook, with one exception. Element 31, Accept Assignment, is required to be "Yes" if the provider wants HIRSP to send payment to the provider. If this element is blank or is "No," HIRSP sends payment to the policyholder. All other instructions in the Wisconsin Medicaid pharmacy handbook apply.

HIRSP's drug claim form may be obtained from HIRSP by sending written requests, including the type and number of claims, to:

Form Reorder
HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

You may copy the following page (48) to use for pharmacy claims until you order and receive the form-feed provider drug claim form.

Department of Health and Family Services
Division of Health
DOH 0126 (4/98)

State of Wisconsin
ss. 149, Wis. Stats.

**WISCONSIN HEALTH INSURANCE RISK SHARING PLAN (HIRSP)**
**Telephone (608) 221-4551 (local), 1-800-828-4777 (toll free)**

ICN (DO NOT WRITE IN THIS SPACE)

1. PROVIDER NAME AND ADDRESS

2. VARIANCE

3. PROVIDER NUMBER

## HIRSP DRUG CLAIM FORM

**Instructions to complete this form can be found in the Medicaid Provider Pharmacy Handbook, Part J**

### POLICYHOLDER/SUBSCRIBER INFORMATION

4. POLICYHOLDER ID NO. | 5. LAST NAME | 6. FIRST NAME | 7. SEX | 8. DATE OF BIRTH | 9. NURSING HOME FACILITY NUMBER

### BILLING INFORMATION

| | 10. PRESCRIBER NUMBER | 11. DATE PRESCRIBED | 12. DATE FILLED | 13. REFILL | 14. NDC | 15. DAYS SUPPLY | 16. QUANTITY | 17. CHARGE |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | $ |
| | 18. UD | 19. PRESCRIPTION NUMBER | 20. MAC | 21. DRUG DESCRIPTION - REQUIRED IF COMPOUND - OTHERWISE OPTIONAL | | | 22. POS | |
| 2 | | | | | | | | $ |
| | | | | | | | | |
| 3 | | | | | | | | $ |
| | | | | | | | | |
| 4 | | | | | | | | $ |
| | | | | | | | | |
| 5 | | | | | | | | $ |
| | | | | | | | | |
| 6 | | | | | | | | $ |
| | | | | | | | | |

23. CERTIFICATION

I CERTIFY THE SERVICES AND ITEMS FOR WHICH REIMBURSEMENT IS CLAIMED ON THIS CLAIM FORM WERE PROVIDED TO THE ABOVE NAMED POLICYHOLDER PURSUANT TO THE PRESCRIPTION OF A MEDICAID-CERTIFIED, LICENSED PHYSICIAN, PODIATRIST, OR DENTIST.

PROVIDERS MUST ACCEPT THE HIRSP PAYMENT RATES DETERMINED BY WISCONSIN STATUTES AS PAYMENT IN FULL. PROVIDERS CANNOT BILL THE POLICYHOLDER FOR THE DIFFERENCE BETWEEN THE CHARGE FOR THE SERVICES AND THE AMOUNT ALLOWED BY HIRSP.

PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE _____ DATE _____

25. PRIOR AUTHORIZATION NUMBER

26. O.I. | 27. T-18

28. TOTAL CHARGES $

29. O.I. AMOUNT $

30. NET BILLED $

31. ACCEPT ASSIGNMENT ☐ YES ☐ NO

| POS | DESCRIPTION |
|---|---|
| 0 | PHARMACY |
| 2 | OUTPATIENT HOSPITAL SERVICES |
| 3 | DOCTOR'S OFFICE |
| 4 | HOME (IV-IM SERVICES ONLY) |
| 7 | N/H EXTENDED CARE FACILITY |
| 8 | SKILLED NURSING FACILITY |

24. PATIENT ACCOUNT NUMBER

**RETURN TO:**
**HIRSP**
**6406 Bridge Road, Suite 18**
**Madison, WI 53794-0018**

# Appendix 4
# Provider Adjustment Request Forms

Providers should use these forms only to request HIRSP to adjust a paid or partially paid claim. Please photocopy the following pages for your use. HIRSP does not supply providers with these forms. Use the appropriate form for your claim: medical (page 51) or drug (page 52). Direct your questions to HIRSP Customer Service at (800) 828-4777 or (608) 221-4551. Detailed instructions for completing both forms are on the following page.

HIRSP requires providers to submit all claims and claim adjustments within 15 months of the date the service was provided.

# Instructions for the Health Insurance Adjustment Request Forms

The adjustment request form is used to request an adjustment of a paid or partially paid claim. A claim that HIRSP totally denied may be resubmitted through normal channels after the payee supplies the additional information or makes the necessary correction to the claim.

HIRSP reviews the adjustment request form based on the information provided to the plan administrator. Be as specific as possible. Complete the adjustment request as follows:

***Enter the following information from your Remittance and Status Report***

1. Provider Name.
2. Wisconsin Medicaid provider number to which HIRSP paid the claim (8 digits).
3. Date of the Remittance and Status (R/S) Report showing the paid claim you are adjusting.
4. Claim number of the paid/allowed claim (15 digits).
5. Complete name of the Wisconsin HIRSP policyholder for whom payment was received (Last, First, Middle Initial).
6. Policyholder's HIRSP identification number (10 digits).
7. Payee for the claim (provider or policyholder).

***To add a detail(s)***

If submitting an adjustment to add a detail(s) to a paid/allowed claim, enter the complete information you are requesting to be added to the claim in elements under section 8.

***To correct a detail(s)***

If submitting an adjustment to correct a detail(s) on a paid/allowed claim, enter the information from the R/S Report in elements under section 8. Enter the correct information in the "Other/Comments" comment area under section 9.

***Reason For Adjustment***

Check one of the following boxes indicating your reason for submitting the adjustment:

- *Recoup Entire Payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other Insurance Payment.* Enter the amount paid by the other insurance carrier.
- *Medicare Reconsideration.* Attach both the original and the new Explanation of Medicare Benefits (EOMB). (If HIRSP paid the claim as a straight HIRSP claim, submit an adjustment for HIRSP to recoup that claim then submit a new claim with the EOMBs attached.)
- *Correct Detail on Previously Paid/Allowed Claim.* Complete elements under section 8 with the information from the R/S Report. Enter the correct information in the "Other/Comments" area below.
- *Other/Comments.* Add any clarifying information not included above. If there are extenuating circumstances, complicated or new procedures, attach a report, history, and physical, operative, or anesthesia report.

***Enter the following***

10. Authorized signature.*
11. Date of signature.*
12. Indicate if a corrected claim form is attached. This is optional but may allow your adjustment to be processed more quickly and accurately.

* If the date or signature is missing on the adjustment request form, the adjustment will be denied.

Please do not include any questions or request information concerning policies or procedures when submitting an adjustment request.

## Wisconsin Health Insurance Risk Sharing Plan (HIRSP)
## Health Insurance
## Medical Adjustment Request Form

1. PROVIDER NAME _____

2. PROVIDER NUMBER | | | | | | | | |

DO NOT WRITE IN THIS SPACE

3. R/S DATE _____

5. POLICYHOLDER NAME _____

4. CLAIM NUMBER | | | | | | | | | | | | | | |

6. POLICYHOLDER NUMBER | | | | | | | | | |

7. PAYEE ☐ PROVIDER ☐ POLICYHOLDER

☐ ADD NEW DETAIL(S) ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 8, enter information to be added).

☐ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 8, enter information as it appears on R/S Report).

### 8. ENTER INFORMATION FROM CLAIM AND R/S REPORT

| DATES OF SERVICE FROM | TO | POS | TOS | PROCEDURE/REVENUE CODE | MOD | MOD | BILLED AMT | UNIT QTY | EMG | PERFORMING PROVIDER |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

### 9. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE PAYMENT.

☐ OTHER INSURANCE PAYMENT $ _____ (OI-P).

☐ MEDICARE RECONSIDERATION (EOMBs ATTACHED).

☐ CORRECT DETAIL (Enter information in 8 as it appears on R/S Report. Enter correct information below.).

☐ OTHER/COMMENTS:

| 10. SIGNATURE | 11. DATE |
|---|---|
| | |

MAIL TO: HIRSP
6406 BRIDGE ROAD, SUITE 18
MADISON, WI 53784-0018

12. ☐ CLAIM FORM ATTACHED (OPTIONAL)

# Wisconsin Health Insurance Risk Sharing Plan (HIRSP)
## Health Insurance
## Drug Adjustment Request Form

1. PROVIDER NAME _____

2. PROVIDER NUMBER | | | | | | | | |

DO NOT WRITE IN THIS SPACE

3. R/S DATE _____

5. POLICYHOLDER NAME _____

4. CLAIM NUMBER | | | | | | | | | | | | | | |

6. POLICYHOLDER NUMBER | | | | | | | | | | |

7. PAYEE ☐ PROVIDER ☐ POLICYHOLDER

☐ ADD NEW DETAIL(S) ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 8, enter information to be added).

☐ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 8, enter information as it appears on R/S Report).

## 8. ENTER INFORMATION FROM CLAIM AND R/S REPORT

A

| 10. PRESCRIBER NUMBER | 11. DATE PRESCRIBED | 12. DATE FILLED | 13. REFILL | 14. NDC | 15. DAYS SUPPLY | 16. QUANTITY | 17. CHARGE |
|---|---|---|---|---|---|---|---|
| | | | | | | | $ |

| 18. UD | 19. PRESCRIPTION NUMBER | 20. MAC | 21. DRUG DESCRIPTION - REQUIRED IF COMPOUND - OTHERWISE OPTIONAL | 22. POS |
|---|---|---|---|---|
| | | | | |

B

| 10. PRESCRIBER NUMBER | 11. DATE PRESCRIBED | 12. DATE FILLED | 13. REFILL | 14. NDC | 15. DAYS SUPPLY | 16. QUANTITY | 17. CHARGE |
|---|---|---|---|---|---|---|---|
| | | | | | | | $ |

| 18. UD | 19. PRESCRIPTION NUMBER | 20. MAC | 21. DRUG DESCRIPTION - REQUIRED IF COMPOUND - OTHERWISE OPTIONAL | 22. POS |
|---|---|---|---|---|
| | | | | |

C

| 10. PRESCRIBER NUMBER | 11. DATE PRESCRIBED | 12. DATE FILLED | 13. REFILL | 14. NDC | 15. DAYS SUPPLY | 16. QUANTITY | 17. CHARGE |
|---|---|---|---|---|---|---|---|
| | | | | | | | $ |

| 18. UD | 19. PRESCRIPTION NUMBER | 20. MAC | 21. DRUG DESCRIPTION - REQUIRED IF COMPOUND - OTHERWISE OPTIONAL | 22. POS |
|---|---|---|---|---|
| | | | | |

## 9. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE PAYMENT.

☐ OTHER INSURANCE PAYMENT $ _____ (OI-P).

☐ MEDICARE RECONSIDERATION (EOMBs ATTACHED).

☐ CORRECT DETAIL (Enter information in 8 as it appears on R/S Report. Enter correct information below.).

☐ OTHER/COMMENTS:

| 10. SIGNATURE | 11. DATE |
|---|---|
| | |

MAIL TO: HIRSP
6406 BRIDGE ROAD, SUITE 18
MADISON, WI 53784-0018

12. ☐ CLAIM FORM ATTACHED (OPTIONAL)

# Appendix 5
# Remittance and Status Reports

The following are explanations of each element of the HIRSP Remittance and Status (R/S) Report. A sample of this report is on page 56.

## Header Information

**1. Name and address** — The name and address of the payee.

**2. R/S number** — The HIRSP R/S Report number.

**3. Payment ID number** — The policyholder's eight-digit payee ID number, a reference number for payment purposes only. This is *not* the ten-digit HIRSP enrollment ID number that should be submitted with claims.

**4. Report seq number** — Sequence number used by HIRSP personnel only.

**5. Date** — The date HIRSP printed the R/S Report.

**6. Page** — Page number. Claim information generally starts on page 2.

## Paid or Denied Claims

HIRSP receives most of this information from the claim form submitted by the provider of services.

**7. Patient name/ID number** — Patient's last name and first name (or first initial) followed by the policyholder's ten-digit HIRSP enrollment ID number. The policyholder's most current name on file will always appear on the HIRSP R/S Report.

**8. Medical record number** — Patient medical record number as recorded on the claim.

**9. Accounting number** — Patient account number as recorded on the claim.

**10. Claim number** — The unique 15-digit number assigned to the claim or claim adjustment.

**11. Service dates** — The date(s) the service(s) or supply item(s) were provided.

**12. UD** — The unit dose indicator from the claim form, when applicable.

**13. NS** — The no substitute indicator from the claim form, when applicable.

**14. Performing provider/ Rx number** — The performing provider number of the provider who performed the service, or the prescription number on a pharmacy claim, when applicable.

**15. Days/Quantity** — Number of visits, days, or supply quantity.

**16. Procedure/ Accommodation/ Drug code** — Code for the service(s) or supply item(s) provided.

**17. Procedure/ Accommodation/ Drug description** — Narrative description of the service(s) or supply item(s) provided.

**18. Total billed** — Total billed charges for the service(s) or supply item(s) shown on that line.

**19. Total allowed** — The amount HIRSP will consider for payment before deductibles and coinsurance.

**20. Ded** — The portion of the **Total allowed** that was applied to the policyholder's deductible.

**21. Coins** — The portion of the **Total allowed** that was applied to the policyholder's coinsurance.

**22. Other deducted charges** — The charges subtracted from the **Total allowed** for reasons such as other insurance payment.

**23. Paid amount** — Amount of the HIRSP payment.

**24. EOB codes** — The numeric code which corresponds to a printed message about how the claim processed. A list of the EOB codes used, with their narrative description, appears on the last page of the R/S Report.

**25. Claim types sub-total** — Subtotals of **Total billed**, **Total allowed**, **Ded**, **Coins**, **Other deducted charges**, and **Paid amount** for similar types of claims (pharmacy, physician, hospital, etc.).

**26. Paid Claim Totals** — Totals of **Total billed**, **Total allowed**, **Ded**, **Coins**, **Other deducted charges**, and **Paid amount** for all claims that were not denied.

## Claims Payment Summary

For these items, a calendar year represents the period beginning January 1 and ending December 31 of the same year.

**27. Claims paid**
- Current processed — Total number of claims processed on this R/S Report.
- Year-to-date total — Total number of claims processed for this payment ID number for the current calendar year.

**28. Claims amount**
- Current processed — Total dollar amount for the claims paid on this R/S Report.
- Year-to-date total — Total dollar amount for claims paid for this payment ID number for the current calendar year.

**29. Withheld amount**
- Current processed — Dollar amount of any withheld payments on this R/S Report.
- Year-to-date total — Dollar amount of payments withheld for this payment ID number for the current calendar year.

**30. Credit amount**
- Current processed — Dollar amount of any voluntary refunds applied in the previous week.
- Year-to-date total — Dollar amount of voluntary refunds applied to this payment ID number for the current calendar year.

**31. Net amount**

| | |
|---|---|
| Current processed | Net amount of this R/S Report. |
| Year-to-date total | Net amount for this payment ID number for the current calendar year. |

# REMITTANCE AND STATUS REPORT

(1) MEDICAL CONS
SUITE 516
CHICAGO, IL 60673 (5)

(2)

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018
608/221-4551
800/828-4777 (8)

PAYMENT ID NUMBER (3) 33070900 (9) REPORT SEQ NUMBER (4) 2 DATE 06/03/98 R/S NUMBER 891 PAGE 62 (6)

| PATIENT NAME/ID NUMBER | SERVICE DATES FROM | SERVICE DATES TO | UNITS OR DAYS | PERF PROV/ RX NUMBER | MEDICAL RECORD NO / DAYS QTY | ACCOUNTING NO / PROC/ACCOM/ DRUG CDE/M1 M2 | PROCEDURE/ACCOMODATION/DRUG DESCRIPTION | CLAIM NUMBER | TOTAL BILLED | TOTAL ALLOWED | DED | COINS | OTHER DEDUCTED CHARGES | PAID AMOUNT | EOB CODES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PAID OR DENIED CLAIMS | | | | | | | | | | | | | | | |
| (7) CO D /211000007 | | | | | | | | | | | | | | | |
| CORN (11) | 011998 | 011998 | 1 | 10000007 | 3000 | 00777310401 | PRO 10MG PULVULE | 109898153062000 | 3900 | 3900 | 00 | 00 | 00 | 3900 | 00889 |
| CORN DA E /211000007 | 021998 | 021998 | 1 | 97342 | 3000 | 00777310401 | PRO 10MG PULVULE | 109898153024000 | 3900 | 3900 | 3900 | 00 | 00 | 00 | 00889 |
| CORN ED S /211100007 | 051898 | 051898 | 1 | 11248 | | 00169244210 | | 109898153001000 | 4000 | 00 | 00 | 00 | 00 | 00 | 00617889 |
| (25) CLAIM TYPE SUB-TOTAL | | | 3 | | | | | | 11800 | 7800 | 00 | 00 | 00 | 3900 | |
| (26) PAID CLAIM TOTALS | | | 842 | | | | | | 3787300 | 71564 | 67664 | 00 | 00 | 3900 | |

CLAIMS PAYMENT SUMMARY FOR CHECK NUMBER 1000729 IN AMOUNT OF $39.00

| | CLAIMS PAID (27) | CLAIMS AMOUNT (28) | WITHHELD AMOUNT (29) | CREDIT AMOUNT (30) | NET AMOUNT (31) |
|---|---|---|---|---|---|
| CURRENT PROCESSED | 842 | 39.00 | 00 | 00 | 3900 |
| YEAR-TO-DATE TOTAL | 845 | 41.06 | 00 | 00 | 4106 |

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE
617 CLAIM DENIED. PLEASE VERIFY THE UNITS AND DOLLARS BILLED. CORRECT CLAIM OR SUBMIT PAPER CLAIM NOTING THAT VERIFICATION HAS OCCURRED.
889 PRESCRIBING PHYSICIAN'S NUMBER SUPPLIED IS NOT ON CURRENT PROVIDER FILE. VALID NUMBERS ARE IMPORTANT FOR DUR PURPOSES. PLEASE VERIFY THAT NUMBER SUBMITTED IS CORRECT.

**HIRSP**
**6406 Bridge Road, Suite 18**
**Madison, WI 53784-0018**
**(800) 828-4777 or (608) 221-4551**

BULK RATE
U.S. Postage
PAID
Madison, WI
53713
Permit No.
1330